How to Respond to Over-Prescribing Doctors

Dr Darrin Baines

In most areas, it is possible to identify practices that spend significantly more on drugs per patient than their peers. Although this is a common occurrence, there are differing opinions about how these over- prescribing practices should be approach. On the one hand, there is a school of thought that argues they should be ignored, as unyielding cases whose behaviour cannot be changed. On the other, it is often argued that no practice over-prescribes, and that any observed differences simply result from a failure of our existing measures of prescribing variation to account for all legitimate determinants of variances in costs. In between these two extremes is the view that overprescribing is a real problem that primary care organisations should address.

Given the problems they often cause for local budget management, primary care groups and trusts need some strategy for working with over-prescribing practices in order to help control their expenditure on drugs. In response, this paper discusses some of the problems encountered when trying to measure variations in local medicines spends, and outlines three main approaches that primary care organisations could incorporate into their strategies for dealing with this group of doctors. In conclusion, the paper argues that, in the short-term, high-cost prescribing may be address through a range of easy to use strategies. However, if the problem persists in the longer-term, steps should be taken to make the offending parties less involved in the act of selecting and prescribing drugs.

Measuring over-prescribing

Before approaching a practice as an "over-prescriber", primary care organisations should check that the label fits. Currently, prescribing costs are normally measured using data routinely provided by organisation such as the Prescription Pricing Authority in England, or the Prescribing Information System for Scotland. These systems usually calculate prescribing expenditures by summing the values of individual prescriptions dispensed in the community for each practice. As a result, the data is not able to measure whether the prescription provided is actually needed in the sense that its use will improve patient health status, or the length of patients' lives. Therefore, when primary care organisations measure variations in prescribing costs, they have no direct information on how these variations relate to patient needs.

Prescribing costs measures

As differences in drug expenditures do not necessarily reflect variations in need, several attempts have been made to produce measures that account for age and sex related variances in medicine costs. In England, the Age, Sex, Temporary Resident Originated Prescribing Unit (ASTRO-PU) and the ASTRO(97)-PU have been developed to measure the variations in costs related to the demographic groups mentioned in its title. In Scotland, the Scottish Prescribing Unit (SCOT-PU) and the SCOTR-PU have been developed to serve the same purpose.

Although the above measures describe approximately 40 per cent of the variation in costs, in recent years new, more comprehensive ways of measuring the legitimacy of differences in medicines expenditures have been suggested. For example, an ASTRO-PU for nursing home patients and a needs adjustment formula for prescribing have been produced by researchers at the National Prescribing Centre and the University of York. Although they improve upon the ways in which prescribing cost variations may be compared, these measures are not perfect and do not account for all legitimate variations in needs or prescribing behaviour.

Prescribing cost benchmark

The above approach to measuring prescribing expenditures produces a "benchmark" against which variations in costs may be measured. In using this approach, primary care organisations have to divide total expenditure on medicines in each local practice by the total "needs" weightings given to them by the various measures. For example, a practice with 5,000 patients may be given a total weighting of 15,000 by the ASTROPU due to the demographic profiles of its list. When the practice's total expenditure on drugs (which we may assume is £1,500,000) is divided by its total demographic weights, the average cost per weighted patient is £100. By comparing this figure with similar calculations for other local practices, the local variation in costs may be established and high cost prescribers identified.

Although it is more sophisticated than simply measuring prescribing costs per patients, the benchmark approach is not free from limitations of its own. Most importantly, the measures used to calculate cost variations may not directly measure need, and may be unable to account for variations in costs caused by differences in clinical practice by individual prescribers. For example, the ASTRO-PU's weights allocate a weighting of 12 to each female over the age of 75, regardless of whether patients in this group need more or less medicines. Also, the measure fails to account for variations in costs caused by doctors in some practices specialising in prescribing for particular diseases. In consequence, the benchmark approach is only really designed for the average practice, and struggles to "explain" substantial (but legitimate) difference from the norm.

Supplementary information

Given the limitations of the current means of measuring prescribing cost variations, practices should not be accused of being over-prescribers to unless they are proved performance be so by a range of different indicators. For example, indicators such as generic prescribing high rates, cost use of drugs of limited value, or prescription of information products could be used to supplement the prescribing provided by a benchmark. Also, total reflect costs could be divided into sub-classes that different therapeutic areas or drug groups. For instance, costs in each British National Formulary chapter could be calculated as percentages of a practice's primary overall spend. By following this approach, care organisations could develop a "picture" of why local practices over-prescribe.

Responding to the picture

Before they approach individual practices, primary care organisations should decide which set of benchmarks and performance indictors will be applied to all local practices so that over-prescribers may be identified. The bodies should also have a procedure or weighing up the costs and benefits of higher cost prescribing that the picture suggests results in more need being met. In other words, primary care organisations should establish a local prescribing plan that outlines their particular priorities and objectives, states what is considered to be cost-effective prescribing and outlines how meeting need is to be traded-off against the requirement to stay within the local allocation for drugs.

Unless each primary care organisation establishes a local norm for prescribing, it is very difficult to state which practices really over-prescribe. Without a local policy against which prescribing behaviour may be compared, over-prescribing may be inappropriately equated with high levels of spending. For example, a local practice may be incorrectly vilified for having higher costs when these actually result from a greater, but more appropriate use of drugs for common condition such as asthma, coronary heart disease and the like. In this instance, the high cost prescriber may be the best prescriber, and all other practices should follow suit.

Developing a strategy

In developing a local prescribing strategy, three main approaches to changing local prescribing behaviour may be adopted. Firstly, information, audit and education can be provided to high cost practices, so that they know they are different, they know why they are different, and they know how to change. Secondly, incentives and objectives may be set for each offending practice, so that they know what they have to achieve and are motivated to secure the desired alterations in their behaviour. Finally, opportunities could be created for high-cost prescribers to become involved in discussions and information sharing with other local doctors about local prescribing practice and policy.

When incorporating the above approaches into a local strategy for addressing over-prescribing, primary care organisations should use obvious and innovative ways of stimulating change. For example, visits by prescribing advisors and the setting of prescribing advisors are commonly used, obvious strategies. However, other, less obvious means could be chosen. For example, places could be funded at a conference for prescribers who reach a defined set of prescribing targets, or the worst prescribers could be put in charge of training other local prescribers.

Dealing with the worse cases

Even if they employ a range of established and innovative approaches to securing change, some doctors will always over-prescribe. If such behaviour threatens the safety of individual patients, Local Medical Committees should subject these individuals to a professional review and investigation. However, if patients are not threatened, but the ability of a primary care organisation to meet its financial targets is challenged, other means of dealing with these individuals may be required. For example, nurse prescribing and pharmacist review could be funded for such practices so that their involvement in drug prescribing and choice is reduced. If this does not work, the offending parties could be funded to things that give them less time to prescribe. For example, they could be paid to spend part of the week working in secondary care. In the long run, however, if a doctor continually wastes public money on expensive, unnecessary prescribing, then a range of strategies should be employed that limit the ability of the offending parties to remain as providers of NHS services.

Conclusions

Over-prescribing is a contentious issue, particularly as higher costs do not necessarily mean that a practice prescribes inappropriately. In response, primary care organisations should agree on which set of available information best paints a picture of the appropriateness of local prescribing behaviour, and develop a local strategy for stimulating change. However, in the long term, if particular practices fail to improve their prescribing behaviour attempts should be made to exit them as providers of services to local patients.